

Connecting with Physicians:

The Hospital Problem that No One Talks About

A nurse new to the ER is told to contact the on-call cardiologist, stat. After five minutes of looking around for the call schedule, she finds it in a 4-inch thick, 3-ring binder, filled with scribbled notes and as confusing as calculus.

Another 10 minutes pass before someone finally gives her the contact information. She places multiple calls to the physician's phone and pager numbers, but no one responds because this doctor is no longer on call. As the patient's condition worsens, the frazzled nurse tries to figure out what to do next.

A scene from a TV show? No, just a dramatization of the communication breakdowns that can occur when nurses and clinicians need to connect with on-call physicians.

When you consider that a 300-bed hospital contacts physicians, on average, about 180,000 times each year—or 500 times a day—it's no surprise that some of these interactions could be problematic. If only 3% have errors or delays that translates into more than 5,000 clinical communication events a year that could adversely affect the quality of care.

In fact, a recent study found that **14% of all pages from two hospitals were sent to the wrong physician, and 15% of the wrong pages were in life-threatening situations that required immediate action.**

Amazingly, however, the vast majority of hospitals seem to accept such everyday breakdowns as the status quo. What makes this especially difficult to understand is the fact that **The Joint Commission has cited communication breakdown as the single greatest contributing factor to sentinel events and delays in care in U.S. hospitals.**

Why Breakdowns Occur

The source of errors, delays and miscommunications often can be traced to hospitals' antiquated methods for managing the contact process with physicians. Many departments still have multiple binders and Rolodex's with page after page of physician names; phone, pager, office and answering service numbers;

preferred methods of contact; call schedules; alternative physicians to contact; etc. For example, nurses and operators at St. John Hospital and Medical Center in Detroit at one time had more than 1,200 sets of physician call preferences and decision algorithms to decipher and figure out whom to contact and how.

Nurses and clinicians must interpret what all this information means for each and every communication event.

Cynthia Pearsall, the chief nursing officer at Fairfield Medical Center in Lancaster, OH, talks about the challenges: "Physicians have very complicated algorithms for contacting them. If it's Tuesday, then you call me here, but if it's Wednesday in the morning you call me some place else, but never use my cell phone and always use my pager unless it's after 7 o'clock. We used to have to look up this information and figure out what to do every time we needed to reach a physician."

Further exacerbating the potential for problems is the fact that call schedules and contact information are not always in one location and rarely up to date.

As one nurse commented, "We have two card files in my department with all the physician information. And I can guarantee you that the information between them is not consistent." Veteran floor and ER nurses also may know physicians and/or their private numbers they can call in emergencies, but they are not always present and often do not share this information.

Although department managers and nurse supervisors know about these communication snafus, they usually do not view them as a systemic problem until they are a contributing factor in an adverse event. CMOs, CNOs and patient safety and quality executives have even less awareness of their extent and impact.

At many hospitals, no one even talks about physician communications as a process to be improved, in part because they are unaware how easily and cost effectively this can be done.

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A Better Solution: Easy, Error-Free Connections

The key to any kind of process improvement is to minimize variability. When contacting physicians, this means eliminating unnecessary steps, hand-offs and decision points, which not only slow down or halt the process but also increase the likelihood of miscommunications. The model for such a simplified, streamlined process is the clinical communication system from PerfectServe, which enables hospitals to facilitate, expedite and manage all types of clinician-to-clinician communications. Here's how it works.

The first step is assembling the call schedules, contact preferences and workflow rules for every physician. The PerfectServe system then integrates all this information to create algorithms that ensure each call, text, voice, email message, or page is sent to the right physician for that particular moment in time. It also gives physicians complete control over the inbound communications they receive, since they can filter and prioritize their interactions based on such factors as who is sending the message (doctor or nurse), hospital facility and department, and the time, day, clinical situation, and urgency. For critical situations that require immediate action, the system automatically escalates notification actions, which might include contacting alternative physicians, to expedite timely responses.

Currently, clinicians can access PerfectServe by dialing a single number and speaking the name of the physician or call group they wish to reach. In the near future, they also will be able to make these connections through iPhones and a Web portal. More than 20 hospitals currently use this system for fail-safe, error-free clinician communications, and the company processes more than 30 million connections each year.

A Cornerstone for Coordination of Care

Faster, more accurate communications among clinicians provides obvious benefits related to patient safety and risk reduction. In time-critical situations, nurses and clinicians no longer must waste minutes and even hours trying to reach a physician, arrange for consults or bring together various members of care-giving teams.

Several hospitals, for example, use PerfectServe to reduce the response time for mobilizing ICU, code stroke or catheterization teams. In addition, by documenting and confirming each point of contact in the communication process, hospitals reduce liability risks for themselves and physicians.

Greater efficiency in this neglected aspect of clinical communications also supports a broader objective shared by all hospitals, i.e., improving the coordination of care.

Although hospital executives usually link this goal with Electronic Medical Records (EMRs), coordinating care involves much more than having access to digitized patient information. Health care happens in real time, and requires physicians, nurses and other clinicians to talk with each other to make good decisions. Enhancing their ability to connect—clinician-to-clinician—facilitates more effective collaboration, particularly in time-sensitive situations, and leads to better patient care.

Basic communication activities such as how hospitals go about contacting their physicians can become so ingrained in practice that no one pays them any attention.

Too often, however, these processes are broken beyond repair, and ignoring them can be a costly mistake.

In the future, hospital payment models will be linked to value-based care, which is dependent upon effective care coordination, which in turn requires timely and reliable clinician-to-clinician communication.

As hospitals continue to spend millions of dollars in efforts to collect, standardize and eventually share data in EMRs, they also should take this into account: An EMR won't help the patient one bit when an ER nurse can't reach the doctor who needs to review a record and determine the best course of action.

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